



HEALTH INFORMATION

Today's Date: ___ / ___ / ___

STUDENT'S NAME _____ GENDER (M / F) DOB ___ / ___ / ___ GRADE _____

Student's Physician _____ Phone (_____) _____ - _____

_____ Street _____ Town _____ State _____ Zip _____

Student's Dentist _____ Phone (_____) _____ - _____

_____ Street _____ Town _____ State _____ Zip _____

Health History: Life Threatening Allergies

Indicate if your child has a *Physician verified* allergy to any of the following. *If yes, please provide official documentation by your child's physician to the school nurse at the beginning of the school year.

Bee Stings _____ Peanuts _____ Nuts _____ Other Food _____ Medications _____

Describe your child's allergy reaction _____

Emergency Care Plan _____

Is Epi Pen required? Yes No Is Benadryl required Yes No

Has Epi Pen ever been used? Yes No Has Benadryl ever been used? Yes No

Does your child carry his/her Epi Pen? Yes No Asthma Inhaler Yes No

Indicate treatment for allergic reactions at the school. _____

Other Allergies: Please list.

Medications _____ Lactose Intolerance _____ Seasonal _____

Environmental _____ Other _____

Describe reaction _____ Medication used for symptom _____

Illnesses/Chronic Conditions: Has your child ever had any of the following?

- Asthma Emotional Heart Murmur Mononucleosis Toileting Issues Menstrual Problems Concussion
- Seizures Diabetes Chicken Pox Fainting Kidney Disease Migraine Headaches Chronic Ear Infections
- Tics Scoliosis Pneumonia Tubes in ears Attention Deficit

List any other injuries or illnesses that the School Nurse should be aware of _____

Medications: Please list prescribed and over the counter medication(s) your child takes. Include herbal treatments.

Name of Medication	Reason	Home	School

Eyeglasses & Contact Lenses: My child wears Contacts Eyeglasses

Date of last examination by ophthalmologist or optometrist: ____ / ____ / ____

Sports: Do you know of any reason for your child not to participate in any sport? Yes No

Explain _____

Note: A Physical examination by your child's physician is required annually for interscholastic sport team participation at both the middle and high school level.

MEDICAL INSURANCE

Name of Company _____ Policy Number _____

Subscriber's Name _____

No Insurance?

Indicate if you wish to have information on Mass Health

DENTAL HEALTH

Do you have Dental Insurance? YES NO

If yes, does insurance cover: YES NO

Fluoride Treatments _____

Cleanings _____

Sealants _____

Does your child visit the dentist every 6 months? YES NO

Date of last dental exam: ____ / ____ / ____

I grant permission for the School Nurse to share the above information with my child's teachers and coaches. Yes No

MEDICAL RELEASE

If, in the event of an accident during this school year, it becomes necessary for my child to receive medical/dental attention, I authorize the Browning Elementary School / South Lancaster Academy Staff to obtain *Emergency* medical/dental care for my child. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent. I give permission for ambulance transportation to nearest Hospital. Payment for any and all medical treatment is the financial responsibility of the parent/guardian.

Parent/Guardian Signature _____

Date: ____ / ____ / ____

EMERGENCY INFORMATION

First contact in case of emergency (check one): Father Mother Other (specify) _____

Names of at least two local relatives/friends who have consented to assume responsibility of your child in case of illness / accident until you can be reached. Your child will only be released to the care of those listed.

1 _____ (____) ____ - _____

2 _____ (____) ____ - _____

3 _____ (____) ____ - _____

Emergency Person's Name

Relationship

Phone